benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package), and of the population to which coverage will be offered. In addition, the State should submit any other information that will be relevant to a determination that the proposed health benefits coverage will be appropriate for the proposed population.

(2) [Reserved]

### § 440.335 Benchmark-equivalent health benefits coverage.

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value, as determined under § 440.340, that is at least actuarially equivalent to the coverage under one of the benchmark benefit packages described in § 440.330 for the identified Medicaid population to which it will be offered.

(b) *Required coverage.* Benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(4) Well-baby and well-child care, including age-appropriate immunizations.

(5) Emergency services.

(6) Family planning services and supplies and other appropriate preventive services, as designated by the Secretary.

(c) *Additional coverage.* (1) In addition to the categories of services of this section, benchmark-equivalent coverage may include coverage for any additional services in a category included in the benchmark plan or described in section 1905(a) of the Act.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes any of the following four categories of services: Prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the four categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

EFFECTIVE DATE NOTE: At 78 FR 42306, July 15, 2013, § 440.335 was amended by adding paragraphs (b)(7)and (8); revising paragraph (c)(1); and removing paragraph (c)(3), effective Jan. 1, 2014. For the convenience of the user, the added and revised text is set forth as follows:

### § 440.335 Benchmark-equivalent health benefits coverage.

* * * * *

(b) * * *

(7) Prescription drugs.

(8) Mental health benefits.

(c) * * *

(1) In addition to the types of benefits of this section, benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in 1 or more of the standard benchmark coverage packages described in § 440.330(a) through (c) or State plan benefits, described in section 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base-benchmark plans described in 45 CFR 156.100.

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### § 440.340 Actuarial report for benchmark-equivalent coverage.

(a) A State plan amendment that would provide for benchmark-equivalent health benefits coverage described in § 440.335, must include an actuarial report. The actuarial report must contain an actuarial opinion that the benchmark-equivalent health benefits coverage meets the actuarial requirements set forth in § 440.335. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared according to the following requirements:

(1) By an individual who is a member of the American Academy of Actuaries (AAA).

(2) Using generally accepted actuarial principles and methodologies of the AAA.

(3) Using a standardized set of utilization and price factors.

(4) Using a standardized population that is representative of the population involved.

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services).

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

(7) Taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(c) The actuary preparing the opinion must select and specify the standardized set of factors and the standardized population to be used in paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State's result.

### § 440.345 EPSDT services requirement.

(a) The State must assure access to early and periodic screening, diagnostic and treatment (EPSDT) services through benchmark or benchmark-equivalent plan benefits or as additional benefits provided by the State for any child under 21 years of age eligible under the State plan in a category under section 1902(a)(10)(A) of the Act.

(1) Sufficiency. Any additional EPSDT benefits not provided by the benchmark or benchmark-equivalent plan must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits plan, these individuals have access to the full EPSDT benefit.

(2) State Plan requirement. The State must include a description of how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure that these individuals have access to the full EPSDT benefit.

(b) [Reserved]

EFFECTIVE DATE NOTE: At 77 FR 42306, July 15, 2013, § 440.345 was amended by revising the section heading and adding paragraphs (b) through (f), effective Jan. 1, 2014. For the convenience of the user, the added and revised text is set forth as follows:

### § 440.345 EPSDT and other required benefits.

* * * * *

(b) *Family planning.* Alternative Benefit Plans must include coverage for family planning services and supplies.

(c) *Mental health parity.* Alternative Benefit Plans that provide both medical and surgical benefits, and mental health or substance use disorder benefits, must comply with the Mental Health Parity and Addiction Equity Act.

(d) *Essential health benefits.* Alternative Benefit Plans must include at least the essential health benefits described in § 440.347, and include all updates or modifications made thereafter by the Secretary to the definition of essential health benefits.

(e) *Updating of benefits.* States are not required to update Alternative Benefit Plans that have been determined to include essential health benefits as of January 1, 2014, until December 31, 2015. States will adhere to future guidance for updating benefits beyond that date, as described by the Secretary.

(f) *Covered outpatient drugs.* To the extent states pay for covered outpatient drugs under their Alternative Benefit Plan's prescription drug coverage, states must comply with the requirements under section 1927 of the Act.

### § 440.347 Essential health benefits.

(a) Alternative Benefit Plans must contain essential health benefits coverage, including benefits in each of the following ten categories, consistent with the applicable requirements set forth in 45 CFR part 156:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorders, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices, except that such